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Notice of Independent Review Decision

Date: May 22, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral laminotomies/foraminotomies and discectomy left L5-S1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Fellowship Trained Orthopaedic Spine Surgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

TDI

- Utilization reviews (03/21/13, 04/01/13)

Forte

- Diagnostics (02/28/12 – 11/29/12)
- Office visits (06/25/12 – 02/01/13)
- Utilization reviews (03/21/13, 04/01/13)

ODG criteria has been utilized for the denials

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is female who on xx/xx/xx, was walking down the hallway when she turned the corner she slipped and fell backwards against the wall and a door and sustained injury to her lumbar spine.

On February 28, 2012, the patient underwent a magnetic resonance imaging (MRI) of the lumbar spine at. Clinical history included low back pain with radiation

down the left leg laterally. The findings were as follows: (1) A circular focus of high T1 and T2 weighted marrow signal within the L3 vertebral body likely representing a hemangioma. (2) At L4-L5, mildly decreased disc height. (3) At L5-S1, mild disc desiccation and mildly decreased disc height. A 4.8 mm circumferential disc bulge mildly impressing on the thecal sac producing mild bilateral neural foraminal narrowing. There was mild spondylosis anteriorly at L5 and S1.

On June 25, 2012, evaluated the patient for back pain. It was noted that the patient was initially seen at the emergency room (ER) after the injury. Her previous treatment included muscle relaxants, chiropractic treatment, massage therapy, acetaminophen and a compression wrap. She also underwent physical therapy (PT) with unsure number of sessions. The patient described the low back pain as sharp, burning, stinging and throbbing radiating to the left buttock, left thigh and left lower leg. The pain level was 6/10. Her symptoms were made worse by prolonged standing, lifting and bending. She had associated stiffness and leg weakness. She had been referred to a pain specialist for an epidural steroid injection (ESI) which had not been done because she was on anti-coagulants after a cardiac angioplasty. History was positive for hypertension. Current medications included amlodipine, estradiol, Flexeril, gabapentin and Plavix. reviewed the MRI dated February 28, 2012, which showed central herniated nucleus pulposus (HNP) at L5-S1. Examination of the lumbar spine showed 0 ankle jerk bilaterally and positive straight leg raise (SLR) on the left for neuropathy. The patient had left sciatic notch tenderness and positive Sitting Root test on the left. Diagnosis was numbness (hypesthesia), anxiety, lumbar radiculopathy and herniated lumbar disc. opined that the patient should improve with conservative management including ESI. He recommended physical therapy (PT).

On October 30, 2012, performed a maximum medical improvement (MMI) and impairment rating (IR) evaluation. noted following treatment history: *The patient had undergone conservative treatment including passive and active type of treatments which provided some relief. The last date that she received supervised treatment sessions was on or around September 10, 2012. She had received her last prescription medication on or about October 27, 2012. She had received two lumbar ESIs which provided some relief of her adverse symptoms in and around her lumbar spine.* opined that the patient had not reached MMI. She had not been afforded a reasonable, adequate opportunity of care for her injuries. She was going to need additional treatment for her lower back injury and would possibly need surgery for her lower back since conservative treatment had not worked. The patient stated that she was going to see a neurosurgeon on November 9, 2012. referred the patient for MRI of the lumbar spine and electromyography/nerve conduction velocity (EMG/NCV) study.

On November 9, 2012, noted that on September 7, 2012, the patient had received ESI that provided some pain relief for about three days and second injection done on October 5, 2012, had provided six days of pain relief. The patient continued to have lower back pain radiating to the left leg into the buttocks, posterior and

lateral aspect of the thigh, into the calf and the entire foot with burning sensation of the toes and along the foot. She had numbness sensation on the entire foot, posterior thigh and buttocks area very frequently. She had been off PT for about two weeks, but had finished recommended therapy in one-month period. She was utilizing Flexeril, tramadol and Neurontin which did not provide pain relief. She reported worsening of the symptoms and rated her pain as 7-8/10. recommended PT.

On November 13, 2012, MRI of the lumbar spine showed the following findings: (1) At L1-L2: A questionable small right lateral disc protrusion extending into the caudal aspect of the foramen. (2) At L2-L3: Minimal posterior disc protrusion more pronounced along its left lateral margin that did not flatten the thecal sac or produce appreciable encroachment upon either foramen. There was posterior ligamentous hypertrophy. (3) At L3-L4: Minimal posterior disc protrusion more pronounced along its left lateral margin that did not flatten the thecal sac or produce appreciable encroachment upon either foramen. There was posterior ligamentous hypertrophy. (4) At L4-L5: Minimal posterior disc protrusion more pronounced along its left lateral margin and posterior ligamentous hypertrophy producing mild flattening but no significant mass effect upon the thecal sac. There was mild encroachment upon the left foramen. (5) At L5-S1: Mild-to-moderate disc bulge, posterior ligamentous hypertrophy and right facet arthropathy producing mild flattening but no significant mass effect upon the tapering thecal sac. There was mild encroachment upon both foramina.

On November 29, 2012, EMG of the lower extremity showed evidence of a mild axonal neuropathy affecting the peroneal and tibial motor nerves on the left. There was also evidence of mild-moderate chronic denervation patterns occurring in the lower lumbar paraspinal muscle region bilaterally. There was also evidence of mild-moderate chronic denervation patterns as well as some re-innervation occurring in L5-S1 innervated muscles of both lower extremities. These electrodiagnostic findings coupled with sensory sparing were therefore, most likely consistent with an L5-S1 radiculopathy occurring bilaterally of mild-moderate severity left worse than right.

On December 21, 2012, reviewed the EMG studies and MRI of the lumbar spine. The patient reported lower back pain radiating to the left lower extremity down into the foot with numbness and tingling sensation. The pain radiated from the lower back into the posterior and lateral aspect of the thigh into the calf and the entire foot with burning sensation to the toes and foot. The pain level was 8/10. The EMG was positive for mild-to-moderate L5-S1 radiculopathy worse on the left side. recommended follow-up in one week with MRI films. The patient underwent manual muscle strength exam of the lumbar spine.

2013: On January 4, 2013, reviewed the MRI of the lumbar spine which showed foraminal disc herniation at left L5-S1 with bilateral facet hypertrophy resulting in foraminal stenosis left worse than right. The MRI DVD from November 13, 2012, showed spondylosis with bilateral foraminal stenosis and left foraminal HNP at L5-S1. The patient had pain while performing her normal daily activities. assessed

lumbar radiculopathy, herniated lumbar disc and lumbar spondylosis. He opined that the patient had failed to improve with medications, PT and lumbar injections. He felt that the patient would benefit from lumbar decompression.

On February 1, 2013, noted that the patient continued to have lower back pain radiating to the left lower extremity down into the foot with numbness and tingling sensation. The pain radiated from the lower back into the posterior and lateral aspect of the thigh into the calf and the entire foot with burning sensation to the toes and foot. Her pain level was 5/10. The patient was pending psychological evaluation. Examination of the lumbar spine showed 4/5 motor strength in hamstrings and gastrocnemius/soleus, left S1 sensory impairment, 0 ankle jerk bilaterally, left sciatic notch tenderness and positive sitting root test on the left and positive straight leg raise (SLR) at 50 deg on the left. recommended bilateral laminotomies/foraminotomies and left L5-S1 discectomy.

On February 26, 2013, the patient underwent a pre-surgical consultation and behavioral assessment. It was noted that the patient was off work and being treated. She had received various diagnostic tests and participated in several levels of treatment including passive and physical therapy, individual psychotherapy sessions, pain injections and medication managements. The patient scored 33 on Beck Depression Inventory II (BDI-II) consistent with severe depression and 37 on Beck Anxiety Inventory (BAI) consistent with severe anxiety. After administration of individual psychotherapy sessions she scored a 28 on BDI-II and 32 on BAI. Diagnosis was pain disorder with both psychological factors and a general medical condition. The evaluator opined that the patient was psychologically stable to undergo and benefit from recommended surgical procedure.

Per utilization review dated March 21, 2013, the request for outpatient decompression and discectomy at L5-S1 was denied. Following information was noted: *Dispute: Per the peer review dated August 28, 2012, the injury that was received while in the course and scope of employment was limited to a lumbar disc bulge at L5-S1 and a lumbar and left leg sprain/strain. All other injuries, diagnoses, symptoms or test results were disputed and not considered part of the compensable injury. The current prescribed treatment of office visits, diagnostic studies, physical therapy, chiropractic treatment, medications, injections, etc was outside Official Disability Guidelines (ODG) and would require pre-authorization. The Self-Insured would continue to review and process any medication that was considered reasonable and necessary as related to the claim.*

The request was denied with the following rationale: *"This female was injured when she slipped and fell. The medical records indicate the claimant initially had conservative treatment with massage, chiropractic, physical therapy (PT), medication and epidural steroid injection (ESI) with failure to respond. The claimants diagnostic testing noted a lumbar MRI November 13, 2012, that noted multi-level disc protrusions L2-S1, not producing significant mass effect with mild-to-moderate disc bulge at L5-S1, with posterior ligament hypertrophy right arthropathy, producing no significant mass affect. The electro-diagnostic study has documented a mild-to-moderate finding for L5-S1 radiculopathy bilaterally.*

continued to follow the patient with multiple examinations and the most current examination noted on February 1, 2013, focal findings for the first time. Examination on February 1, 2013, noted 4/5 hamstring and gastroc soleus weakness with right S1 and left S1 sensory impairment more pronounced than the right. At this time with the MRI findings being so questionable for producing impingement and the claimant just having a positive neurological finding noted on examination, the claimant at this time should have continued conservative treatment, lacking imaging evidence as recommended by ODG for the requested L5-S1 decompression and discectomy.”

On March 27, 2013, a reconsideration request was submitted for the outpatient decompression and discectomy at L5-S1.

Per reconsideration review dated April 1, 2013, the request for outpatient decompression and discectomy at L5-S1 was denied with the following rationale: *“female slipped and fell and hurt her back. She has had a MRI that noted multilevel degenerative disc disease (DDD). When seen February 1, 2013, she had back and left LE symptoms with 4/5 strength at the hamstrings and Gastroc S1, S1 sensory decrease bilaterally and Achilles reflex absent bilaterally. The EMG is felt to be consistent with chronic bilateral S1 radiculopathy. The SLR is positive only on the left and Lasegue’s negative. MRI on February 28 noted disc dehydration at all levels and there is a 4.8 mm circumferential disc bulge and produces mild bilateral foraminal stenosis with degenerative changes. There is no mention of root displacement or tightness. On March 21, there was a request for Outpatient decompression and discectomy at L5-S1 that was denied as the MRI findings were minimal. For this appeal, there is a letter from the attorney requesting reconsideration but there is no new clinical information provided. The injured worker does not meet the guidelines. The mechanism of injury is inconsistent with the presumed diagnosis, the physical findings are significantly different between the designated doctor and the surgeon, findings are not consistent relative to SLR, numbness and motor findings and finally the MRI does not support the presence of physical pressure on the nerve bilaterally. Therefore, the medical necessity of the requested procedure is not established. The denial is upheld.”*

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The patient is a lady who had a work incident on xx/xx/xx, when she slipped and fell backwards against a door with reported injury to the lumbar spine. She subsequently underwent a lumbar MRI on February 28, 2012, at Sugarland. This showed only mild disc desiccation at L5-S1 with a disc bulge with mild impression on the thecal sac and only mild bilateral neural foraminal narrowing. The other disc levels had no significant disc desiccation reported.

The patient then was evaluated on June 25, 2012. It was noted that the patient had low back pain as well as pain radiation to the left buttock, thigh and lower leg. The patient had been referred for an epidural injection but could not have that

done because of being on anticoagulants for a cardiac angioplasty. reviewed the MRI and reported a herniated nucleus pulposus at L5-S1. He also noted that the ankle jerks bilaterally were absent and there was a positive straight leg raise on the left although this was not further defined. He diagnosed numbness and anxiety, lumbar radiculopathy and disc herniations.

On October 30, 2012, a designated doctor exam was performed. He reported that she had undergone two previous lumbar ESIs which provided some relief of her lumbar symptoms. Reviewer comments: The description of the relief was inadequate to suggest that this had any substantial benefit on a quantified basis. The patient had a subsequent EMG-nerve conduction study which of interest was done who suggested that it supported bilateral L5-S1 radiculopathy, worse on the left side.

The patient then followed up who continued to propose that the patient had failed non-operative care and that she should proceed with operative intervention. Please note that there was another MRI completed on November 13, 2012. This was noted to show only a disc bulge with right facet hypertrophy producing mild flattening but no significant mass effect upon the tapering thecal sac. There is no mention of any foraminal disc protrusion or herniation.

The patient was sent for psychological assessment. The diagnosis was pain disorder with both psychological factors and a general medical condition.

There were two utilization review reports available in the records, one who noted that the patient did not meet ODG criteria for this procedure of discectomy and L5-S1 decompression surgery. A reconsideration was then done. He noted the MRI and clinical findings did not correlate. He specifically noted that the MRI did not show physical pressure on the nerves bilaterally.

Summary

The patient has had a work incident with reported low back injury with symptoms into the left lower extremity greater than right. However, there is no localization on the MRI of any mass effect more towards the left and in fact there is no evidence of any nerve root pressure that would warrant any type of spine surgery. The patient allegedly has electrodiagnostic changes. However, these do not correlate with the MRI and thus would not be evidence for support for doing a spine surgery. Thus, with the records that are forwarded as well as clinical exam, this patient does not meet ODG criteria of necessitating lumbar discectomy or decompression surgery at L5-S1. Thus the adverse determinations are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES